

PLEASE
DO NOT
STAPLE
IN THIS
AREA

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

PICA

PICA

1. MEDICARE
☐ (Medicare #)

MEDICAID
☐ (Medicaid #)

CHAMPUS
☐ (Sponsor's SSN)

CHAMPVA
☐ (VA File #)

GROUP HEALTH PLAN
(SSN or ID)
☐

FECA BLK LUNG
(SSN)
☐

OTHER
(ID)
☐

1a. INSURED'S I.D. NUMBER
(FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE
MM DD YY
SEX
M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED
Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY

STATE

8. PATIENT STATUS
Single ☐ Married ☐ Other ☐

CITY

STATE

ZIP CODE

TELEPHONE (Include Area Code)
()

11. INSURED'S POLICY GROUP OR FECA NUMBER

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:
a. EMPLOYMENT? (CURRENT OR PREVIOUS)
☐ YES ☐ NO
b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)
c. OTHER ACCIDENT? ☐ YES ☐ NO
10d. RESERVED FOR LOCAL USE

11. INSURED'S DATE OF BIRTH
MM DD YY
SEX
M ☐ F ☐

12. EMPLOYER'S NAME OR SCHOOL NAME

13. INSURANCE PLAN NAME OR PROGRAM NAME

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: ☐ ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)
MM DD YY

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE
MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☐ YES ☐ NO \$ CHARGES _____

22. MEDICAID RESUBMISSION CODE _____ ORIGINAL REF. NO. _____

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. _____ 3. _____
2. _____ 4. _____

23. PRIOR AUTHORIZATION NUMBER

A		B	C	D		E	F	G	H	I	J	K
DATE(S) OF SERVICE		Place of Service	Type of Service	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		DIAGNOSIS CODE	\$ CHARGES	DAYS OR UNITS	EPSDT Family Plan	EMG	COB	RESERVED FOR LOCAL USE
From	To			CPT/HCPCS	MODIFIER							
MM	DD	YY	MM	DD	YY							
1												
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER
☐ ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back)
☐ YES ☐ NO

28. \$ TOTAL CHARGE

29. \$ AMOUNT PAID

30. \$ BALANCE DUE

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED _____ DATE _____

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# _____ GRP# _____

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500